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## Senate

### Statement of Senator Dianne Feinstein

#### *“On the OB/GYN Medical Malpractice Reform Bill”*

Mrs. FEINSTEIN. Mr. President, I cannot support this bill. I don't believe it reflects compromise. I don't think it is materially changed from the bill that failed to get 50 votes last July. The major difference, as I see it, in this bill is that the liability restrictions apply to only one medical specialty group, obstetricians and gynecologists.

This bill sets a national cap of \$250,000 for noneconomic damages. The cap applies not only to suits against doctors but to suits against HMOs and to manufacturers of gynecological or obstetric products as well.

So, under this bill, the Dalkon Shield contraceptive device would be shielded by this \$250,000 cap regardless of the harm caused.

Moreover, this bill severely limits the availability of punitive damages against OB/GYNs and manufacturers of related products. The bill would also immunize manufacturers or sellers of gynecological products approved by the FDA from punitive damages.

The FDA exemption sets, in a way, a downward course. If a company has an FDA-approved product on the market and then learns of dangerous complications, the company must remove the product from the marketplace immediately. To provide an exemption for products with FDA approval may well be a disincentive to prompt removal from the shelf.

I am one who believes there needs to be a solution to rising malpractice insurance premiums. I want to talk to that solution in just a moment. But, it is correct that obstetricians and gynecologists are reeling under exorbitant medical malpractice premiums.

Obstetricians and gynecologists had more claims against them and paid out more money to plaintiffs than any other medical specialty between 1985 and 2000.

Prior to the State of Florida passing medical liability caps last year, OB/GYNs in Florida paid over \$200,000 annually for malpractice insurance.

OB/GYNS in California, a State with liability caps, pay an average in malpractice

insurance of \$57,000, which is about a quarter of what it is in Florida.

According to the American College of Obstetricians and Gynecologists, 20 percent of obstetricians and gynecologists in Nevada are leaving their practice due to rising malpractice insurance costs. Twenty percent of OB/GYNs in West Virginia and Georgia have been forced out of their practice. I could go on and on and on.

I want to talk for a moment about California, and then I want to talk about what I think is a logical solution to this. But up to this point, the AMA and my own medical association, the California Medical Association, won't buy it. Congress can and should provide some legislative relief.

MICRA, the Medical Injury Compensation Reform Act, took place 29 years ago in California. MICRA set a precedent in the ensuing years for reform measures in several States. The MICRA law provides a model.

Last year, I spent several months reviewing MICRA to see what could be transferred to the national level. I have come to believe it is possible that reasonable caps on liability can lead to affordable premiums.

When MICRA was enacted in 1975, the cost of health insurance in California was higher than in any market except New York City. In the 6 years before 1975, the number of malpractice suits filed per hundred physicians in California had more than doubled.

MICRA has kept costs down. In 1975, California's doctors paid 20 percent of the gross costs of all malpractice insurance premiums in the country. Today, it is 11 percent.

California's premiums grew 167 percent over the past 25 years compared to 505 percent in other States. So the growth in California is just about less than a third of what it is in the rest of the United States.

In California, patients get their money faster. Cases in California settle 23 percent faster than in States without caps on noneconomic damages.

MICRA allows patients to obtain health care costs, recover for loss of income, and receive the funds they need to be rehabilitated. And California's malpractice premiums are now one-third to one-half lower on average than those in Florida and New York.

The proposal I would put out for people to study today takes those parts of MICRA which I thought could serve as a national model.

For example, a schedule of attorney's fees; a strict statute of limitations requiring that medical negligence claims be brought within 1 year from the discovery of an injury or within 3 years of the injury's occurrence; the requirement that a claimant give a defendant 90 days' notice of his or her intent to file a lawsuit before a claim can actually be filed; allowing defendants to pay damage awards in periodic installments; and allowing defendants to introduce evidence at trial to show that claimants have already been compensated for their injuries through workers' compensation benefits, disability benefits, health insurance, or other payments; and permitting the recovery of unlimited economic damages. All of these points are now in play in California. I believe they are applicable nationally.

The differences from the California MICRA that I would propose would be in two key areas. The first is noneconomic damages, and the second would be punitive damages.

The California MICRA law has a \$250,000 cap on noneconomic damages. That is what is proposed in the pending bill. In contrast, I would propose a national \$500,000 flex cap, a general cap on noneconomic damages. This cap would allow a State to impose a lower or a higher limit, but it would be pivotal for those States where

the State laws do not currently allow a State to set a cap. This would allow in those States for the cap to be \$500,000.

In catastrophic cases where a victim of malpractice was subject to severe disfigurement, severe disability, or death, the cap would be the greater of \$2 million or \$50,000 times the number of years of life expectancy of the victim. This handles the situation of a very young victim who was really the victim of egregious malpractice.

In addition, my proposal would have less onerous punitive damages standards than California law. California law would require a plaintiff to prove punitive damages under the very high standard of fraud, oppression, or malice. Under this standard, I am not aware of a single case where a plaintiff has obtained punitive damages in California over the past 10 years. However, if the State wanted to keep that -- any State -- they could under my proposal.

But I would offer a four-part test where a plaintiff would have to show by clear and convincing evidence that the defendant, (1) intended to injure the claimant unrelated to the provision of health care; (2) understood the claimant was substantially certain to suffer unnecessary injury, and in providing or failing to provide health care services, the defendant deliberately failed to avoid such injury; (3), acted with a conscious, flagrant disregard of a substantial and unjustifiable risk of unnecessary

injury which the defendant failed to avoid; or, (4), acted with a conscious, flagrant disregard of acceptable medical practices in such circumstances. I firmly believe a variant of this type could lead to a compromise in the Senate, but the AMA and my own medical association, the California Medical Association, both flatly rejected this proposal last year.

They refused any cap for noneconomic damages above \$250,000 even in catastrophic cases. To me this makes little sense because a \$250,000 cap in 1975, which was when the cap was put in play in California, adjusted for inflation, was worth \$839,000 in 2002. If \$250,000 was adequate in 1975, why wouldn't a figure of a half a million dollars -- \$500,000 -- which is lower than the cap

adjusted for inflation, be acceptable in 2004? If a victim receives \$250,000 today, it is the equivalent of \$40,000 in 1975 dollars.

There are many specific instances of why a \$250,000 noneconomic damage, especially today, remains too low. Let me just give you one case. I happened to meet this woman, and it is a case that I think makes my argument irrevocably. It is the case of Linda McDougal. She is 46. She is a Navy veteran, an accountant, and a mother. She was diagnosed with an aggressive form of cancer and underwent a double mastectomy. Two days later, she was told that a mistake was made. She didn't have cancer, and the amputation of her breasts was not necessary. A

pathologist had mistakenly switched her test results with another woman who had cancer.

A cap on noneconomic damages must take into account severe morbidity produced by a physician's mistake, such as amputating the wrong limb or transfusing a patient with the wrong type of blood.

I remain a supporter of malpractice insurance reform. If at any time there would be physician support, I believe then the necessary 60 votes in this body could be generated for a plan such as I have just enumerated.

In conclusion, I will vote against this bill but stand ready to participate in a solution along the lines I have mentioned.